DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10093 (10/02)

STATE OF WISCONSIN
Wisconsin Statutes 49.46

MEDICAID OVERPAYMENT NOTICE

INSTRUCTIONS: To be completed by an Economic Support (ES) worker at the county agency and mailed to recipient. Retain a copy for the case file.

Under 49.45(4) Wisconsin Statutes personally identifiable information provided is used directly for Medicaid program administration.

Recipient Name (Last, First, MI)

Recipient Address (Street, City, State, Zip Code)

Overpayments occur when Medicaid benefits are paid for someone who was not eligible for them, or when Medicaid payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the Medicaid benefits incorrectly provided.

You received more Medicaid benefits than you were eligible for. The amount of your overpayment is $_____ in this time period _____(date) to _____ (date).

By law you must repay the overpayment resulting from the type of error checked below. A Medicaid Repayment Agreement will be sent to you that explains how you can repay this overpayment.

Reason for Overpayment

☐ Recipient Error

Recipient error is when a recipient, or any other person responsible for giving information on the recipient's behalf, unintentionally misstated the facts. Recipient error includes:

- Misstatement or omission of facts by a recipient, or any other person responsible for giving information on the recipient's behalf, at a Medicaid application or review.
- Failure on the part of the recipient, or any person responsible for giving information on the recipient's behalf, to report changes within 10 days.

☐ Fraud

Fraud occurs when a recipient intentionally omits or provides erroneous information at the time of application or review.

Explanation of Error:

Right to a Hearing

You have the right to request a fair hearing if you believe the agency's decision that you received a Medicaid overpayment is wrong or if you disagree with the amount of the overpayment. You will receive a Notice of Decision that explains your hearing rights and how to appeal. The notice will explain that you may request a hearing orally or in writing, within 45 days of the date of notice. You may be represented at a hearing by anyone you choose.

SIGNATURE – Economic Support Worker	Date Signed
County Agency Name	**Case Number**

Reset Form